SERFF Tracking Number:	*FRCS-126995957*	*State:*	*Arkansas*
Filing Company:	*Columbian Life Insurance Company*	*State Tracking Number:*	*47828*
Company Tracking Number:	*5431.7*		
TOI:	*L04I Individual Life - Term*	*Sub-TOI:*	*L04I.500 Other*
Product Name:	*Mortgage Term Life*		
Project Name/Number:	*CML-2/61.7/61.7*		

Filing at a Glance

Company: Columbian Life Insurance Company

Product Name: Mortgage Term Life	SERFF Tr Num: FRCS-126995957	State: Arkansas
TOI: L04I Individual Life - Term	SERFF Status: Closed-Approved-Closed	State Tr Num: 47828
Sub-TOI: L04I.500 Other	Co Tr Num: 5431.7	State Status: Approved-Closed
Filing Type: Form		Reviewer(s): Linda Bird
	Author: Jana Finlay	Disposition Date: 01/31/2011
	Date Submitted: 01/28/2011	Disposition Status: Approved-Closed
Implementation Date Requested: On Approval		Implementation Date:

State Filing Description:

General Information

Project Name: CML-2/61.7	Status of Filing in Domicile: Pending
Project Number: 61.7	Date Approved in Domicile:
Requested Filing Mode: Review & Approval	Domicile Status Comments: Submitted on or about this same date.
Explanation for Combination/Other:	Market Type: Individual
Submission Type: New Submission	Individual Market Type:
Overall Rate Impact:	Filing Status Changed: 01/31/2011
	State Status Changed: 01/31/2011
Deemer Date:	Created By: Jana Finlay
Submitted By: Jana Finlay	Corresponding Filing Tracking Number:

Filing Description:

We have been retained by Columbian Life Insurance Company to file the enclosed forms for approval in your state.

Our fee of $100.00 has been sent by EFT on this same date.

The Company previously filed the applications under SERFF Filing FRCS-126924641/ DOI# 47481 and received approval on 12/10/2010. After the applications were approved, the Company noted that questions needed to be revised so they could apply to all applicants for insurance. As a result, questions have been revised to apply to “any proposed insured.” The application form numbers have been revised.

SERFF Tracking Number:	*FRCS-126995957*	*State:*	*Arkansas*
Filing Company:	*Columbian Life Insurance Company*	*State Tracking Number:*	*47828*
Company Tracking Number:	*5431.7*		
TOI:	*L04I Individual Life - Term*	*Sub-TOI:*	*L04I.500 Other*
Product Name:	*Mortgage Term Life*		
Project Name/Number:	*CML-2/61.7/61.7*		

The Company also revised the signature line of Proposed Insured (page 3), by deleting "(Parent/Guardian if 15 or under)" for both applications.

The following change was made in the application FORM NO. A432-CL on the bottom of page 3 and the accompanying checkboxes, by deleting “HAS THE TELEPHONE INTERVIEW BEEN COMPLETED?” in the “Report of Licensed Agent” section.

Other minor changes were made as well. Redlined version of the initial and reinstatement applications, with changes noted, are attached under supporting documentation.

To the best of our knowledge, this filing is complete and intended to comply with the insurance laws of your jurisdiction.

Company and Contact

Filing Contact Information

Jana Finlay, Senior Compliance Specialist
1020 Central
Suite 201
Kansas City, MO 64105

jana.finlay@firstconsulting.com
800-927-2730 [Phone] 2741 [Ext]
816-391-2755 [FAX]

Filing Company Information

(This filing was made by a third party - FC01)

Columbian Life Insurance Company
4704 Vestal Parkway East
P.O. BOX 1381
Binghamton, NY 13902-1381
(800) 328-2739 ext. 203[Phone]

CoCode: 76023
Group Code: 535
Group Name:
FEIN Number: 16-1321681

State of Domicile: Illinois
Company Type:
State ID Number:

Filing Fees

Fee Required?	Yes
Fee Amount:	$100.00
Retaliatory?	No
Fee Explanation:	$50.00 per form x 2 forms = $100.00
Per Company:	No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #

SERFF Tracking Number:	*FRCS-126995957*	*State:*	*Arkansas*
Filing Company:	*Columbian Life Insurance Company*	*State Tracking Number:*	*47828*
Company Tracking Number:	*5431.7*		
TOI:	*L04I Individual Life - Term*	*Sub-TOI:*	*L04I.500 Other*
Product Name:	*Mortgage Term Life*		
Project Name/Number:	*CML-2/61.7/61.7*		

Columbian Life Insurance Company	$100.00	01/28/2011	44170262

SERFF Tracking Number:	*FRCS-126995957*	*State:*	*Arkansas*
Filing Company:	*Columbian Life Insurance Company*	*State Tracking Number:*	*47828*
Company Tracking Number:	*5431.7*		
TOI:	*L04I Individual Life - Term*	*Sub-TOI:*	*L04I.500 Other*
Product Name:	*Mortgage Term Life*		
Project Name/Number:	*CML-2/61.7/61.7*		

Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Linda Bird	01/31/2011	01/31/2011

SERFF Tracking Number:	*FRCS-126995957*	*State:*	*Arkansas*
Filing Company:	*Columbian Life Insurance Company*	*State Tracking Number:*	*47828*
Company Tracking Number:	*5431.7*		
TOI:	*L04I Individual Life - Term*	*Sub-TOI:*	*L04I.500 Other*
Product Name:	*Mortgage Term Life*		
Project Name/Number:	*CML-2/61.7/61.7*		

Disposition

Disposition Date: 01/31/2011
Implementation Date:
Status: Approved-Closed
Comment:

Rate data does NOT apply to filing.

SERFF Tracking Number:	*FRCS-126995957*	*State:*	*Arkansas*
Filing Company:	*Columbian Life Insurance Company*	*State Tracking Number:*	*47828*
Company Tracking Number:	*5431.7*		
TOI:	*L04I Individual Life - Term*	*Sub-TOI:*	*L04I.500 Other*
Product Name:	*Mortgage Term Life*		
Project Name/Number:	*CML-2/61.7/61.7*		

Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification		Yes
Supporting Document	Application		Yes
Supporting Document	Life & Annuity - Acturial Memo		No
Supporting Document	Authorization		Yes
Supporting Document	Mark-up of changes		Yes
Form	Application for Individual Term Life Insurance		Yes
Form	Application for Reinstatement		Yes

SERFF Tracking Number:	*FRCS-126995957*	*State:*	*Arkansas*
Filing Company:	*Columbian Life Insurance Company*	*State Tracking Number:*	*47828*
Company Tracking Number:	*5431.7*		
TOI:	*L04I Individual Life - Term*	*Sub-TOI:*	*L04I.500 Other*
Product Name:	*Mortgage Term Life*		
Project Name/Number:	*CML-2/61.7/61.7*		

Form Schedule

Lead Form Number: FORM NO. A432-CL

Schedule Item Status	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
	FORM NO. A432-CL	Application/ Enrollment Form	Application for Individual Term Life Insurance	Revised	Replaced Form #: FORM NO. A430-CL Previous Filing #: FRCS-126924641/DOI# 47481	50.000	FORM NO. A432-CL-John Doed Distilled.pdf
	FORM NO. A433-CL	Application/ Enrollment Form	Application for Reinstatement	Revised	Replaced Form #: FORM NO. A431-CL Previous Filing #: FRCS-126924641/DOI# 47481	50.000	FORM NO. A433-CL-John Doed Distilled.pdf

COLUMBIAN LIFE INSURANCE COMPANY

HOME OFFICE: CHICAGO, IL
ADMINISTRATIVE SERVICE OFFICE: [4704 VESTAL PARKWAY EAST
PO Box 1381, Binghamton, NY 13902-1381
(800) 423-9765 / www.cfglife.com]

APPLICATION FOR INDIVIDUAL TERM LIFE INSURANCE POLICY

MAIL POLICY TO: ☐ Agent ☑ Owner

1. PROPOSED INSURED

Name (Last, Middle Initial, First)	Social Security Number	Sex	Age	Date of Birth	State of Birth
DOE M John	123-55-6717	M	35	11/16/75	MO

Home Address/Apt. No., City, State, Zip Code: 12 12 St, Kansas City MO 64105

Phone Number: ☒ Home ☐ Work ☐ Cell: (555) 676-1234

2. OWNER (Complete only if Owner is other than Proposed Insured.)

Name of Owner	Social Security Number	Relationship to Proposed Insured

Mailing Address/ (If different from Insured)

3. BENEFICIARY

Primary Beneficiary Designation: (Full Name & Relationship to Insured)	Contingent Beneficiary Designation: (Full Name & Relationship to Insured)
JANE M DOE, SPOUSE	John Doe son

4. POLICY INFORMATION

[Please select your preference for receiving correspondence from us: ☐ US Mail ☒ Email
(If you choose Email please make sure you supply your email address.)]

Email Address: John@Comcast.net

PLAN OF INSURANCE:
☒ 15 Year Term ☐ 20 Year Term ☐ 30 Year Term

50% Return of Premium Benefit
☒ 20 Year Term ☐ 30 Year Term

100% Return of Premium Benefit
☐ 20 Year Term ☐ 30 Year

RIDERS:
[☐ Accidental Death Benefit
☐ Waiver of Premium – Disability
☐ Children's Term Insurance Rider
☐ Accelerated Death Benefit – Terminal Illness
☐ Accelerated Death Benefit – Critical Illness
☐ Disability Income Rider
Monthly Benefit _____]

AMOUNT OF INSURANCE (Face Amount): $10,000

AMOUNT PAID WITH APPLICATION: $0.00

Payment Mode: ☒ **Annual** ☐ **Semi-Annual**
☒ **EFT - Please specify Annual, Semi-Annual or Monthly** _____
☐ **Draft 1st Premium?** (Draft date must be within 30 days of application date. Please see EFT options on Page 4.)

Requested Effective Date: 12-1-10

Children's Rider Amount: _____ **Units (Children are natural, step, and legally adopted children.)**

Name	Sex	Date of Birth	Height / Weight	Beneficiary
			/	Applies to all Children, including Children added after Issue Date.
			/	
			/	NAME:
			/	
			/	RELATIONSHIP:

5. HEALTH HISTORY

SECTION A.	YES	NO
1. Are all proposed insureds US citizens, permanent US residents or holding a permanent Visa?	☑	☐
2. Are you currently employed? If "NO," please explain _____	☑	☐
Occupation: Manager		
Annual Income: 80,000.00 Total Household Income: 100,000.00		
3. Have you obtained a home mortgage or refinanced an existing mortgage, been married and/or had or adopted a child in the last three (3) years? (If "NO," do not continue.)	☑	☐
4. Do you have a Driver's License? If "NO," please provide details: _____	☑	☐
If "YES," Driver's License No. and State: J10117 MO		
5. In the past three (3) years, has any proposed insured:		
▪ Been on probation, parole, been arrested for, convicted or, or pled guilty to any crime or to possession or distribution of drugs or any other illegal substance?	☐	☑
▪ Been convicted of three or more moving violations, been convicted of driving under the influence of alcohol or drugs, or had a driver's license suspended or revoked?	☐	☑
If "YES" to above, please provide details: _____		
6. Have you used tobacco or any nicotine products in the past twelve (12) months (to include cigarettes, cigars, snuff/chew/dip, pipes, nicotine patch and nicotine gum)?	☐	☑

SECTION B. If "YES" to questions in Sections B or C, please provide details in chart below.	YES	NO
1. Has any proposed insured been diagnosed as having Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC), or Human Immunodeficiency Virus (HIV) Infections (symptomatic or asymptomatic) or been treated for AIDS, ARC, or HIV by a physician or health care provider?	☐	☑
2. Has any proposed insured ever received or been recommended for an organ or bone marrow transplant?	☐	☑
3. Is any proposed insured currently:		
a. Bedridden or confined to any hospital, nursing home, or other medical facility?	☐	☑
b. Using any of the following: walker, wheelchair, electric scooter, oxygen or catheter?	☐	☑
If "YES," please provide details: _____		
4. Current Height: 6'1" Current Weight: 189		
Any unexplained history of weight loss of more than 10 lbs. in the last year?	☐	☑
If "YES," please provide details: _____		
5. In the past three (3) years has any proposed insured:		
a. Engaged in: hang-gliding, cliff diving, scuba diving over 130 feet, parachuting, skydiving, rock or mountain climbing, speeds (in any vehicle) in excess of 100 mph (land or water) or plan such activity in the next 2 years?	☐	☑
b. Flown as a student pilot, or private pilot with over 250 flight hours per year, used an ultra-light aircraft or plan such activity in the next 12 months?	☐	☑

SECTION C	YES	NO
1. In the past three (3) years, has any proposed insured been declined, postponed, rated or denied reinstatement or asked to pay extra premium by any insurance company?	☐	☑
2. In the past five (5) years, has any proposed insured:		
a. Used cocaine, narcotics, hallucinogens, barbiturates, amphetamines, marijuana or other drugs except as prescribed by a physician?	☐	☑
b. Been advised by a healthcare professional to reduce or stop alcohol or drug use or received treatment for alcohol or drug abuse?	☐	☑
3. Does any proposed insured have or has had a diagnosis of diabetes prior to the age of 35 and/or experienced complications of diabetes, including insulin shock, diabetic coma, Retinopathy (eye), Nephropathy (kidney), Neuropathy (nerve, circulatory) disorder, leg ulcers, amputation or diabetes not under control with current treatments?	☐	☑
4. In the past ten (10) years, has any proposed insured received a diagnosis of or required follow-up for:		
a. Cancer (other than basal cell or squamous cell carcinoma of the skin), leukemia, or lymphoma?	☐	☑
b. Stroke (CVA), transient ischemic attach (TIA), paralysis?	☐	☑
c. Systemic lupus, sarcoidosis, rheumatoid arthritis, Crohn's Disease or ulcerative colitis, degenerative muscle or nerve disease/disorder, immune system or connective tissue disease/disorder?	☐	☑
d. Schizophrenia, bipolar disorder, major depression, mental retardation, Down's Syndrome, Alzheimer's disease, dementia, Parkinson's disease or Multiple Sclerosis?	☐	☑
e. Coronary artery disease, heart attack, coronary bypass surgery (CABG), coronary angioplasty (PTCA), heart valve replacement, angina, heart arrhythmia, congenital heart disease, cardiomyopathy, congestive heart failure (CHF), pacemaker, defibrillator, aneurysm, disease or disorder of the brain, peripheral arteries, blood, liver, pancreas, or kidney (other than kidney stones)?	☐	☑
f. Emphysema, COPD or asthma that has required one or more acute emergency care visits or an inpatient hospitalization?	☐	☑
g. Epilepsy and recurring seizures with the last seizure occurring within the past year?	☐	☑
5. Is any proposed insured awaiting a diagnosis or been advised to have a surgical operation, a diagnostic test or a medical or mental evaluation that has not been completed?	☐	☑
6. In the past five (5) years, has any proposed insured been prescribed medication or taken any medication prescribed by a physician or been hospitalized or consulted a physician or medical facility for any reason?	☐	☑

TABLE FOR "YES" ANSWERS IN SECTIONS B OR C

Person Proposed for Insurance	Medication Name (Copy from Pharmacy Label)	Date last taken	Name & Address of Physician or Medical Facility	Treatment / Diagnosis	Dates & Durations

6. ANSWER ONLY IF APPLYING FOR THE DISABILITY INCOME RIDER	YES	NO
1. Are you currently covered by Workers Compensation? *(If yes, you are only eligible to apply for an Off-the-Job Disability Income Rider. If so, skip to question #3.)*	☐	☐
2. Occupation Information:		
a. Description of duties _____		
b. Have you been working full-time (at least 30 hours per week) for the last 12 months?	☐	☐
c. If self-employed, % of time working at home? _____		
3. What is the monthly amount of any individual disability insurance you have in force? _____		
4. In the past ten (10) years, have you received care or treatment for, or been diagnosed by a member of the medical profession as having:		
a. Fibromyalgia, Chronic Fatigue Syndrome, Chronic Epstein-Barr, Rheumatoid Arthritis or other inflammatory arthritis?	☐	☐
b. Inflammatory Bowel Disease including Crohn's Disease or Ulcerative Colitis, Diabetes, Skin or Connective Tissue Disorder?	☐	☐
c. Disease or impairment of the spinal column, neck or back, including acute and Chronic neck or back strain; herniated disc syndrome, surgery of the spine or back, acute and chronic sciatica, or congenital disorders of the spinal column and back?	☐	☐
d. Recurring disease or impairment of other bones or joints, e.g. wrist, knee, or shoulder?	☐	☐
e. Any emotional or psychological disorder, including stress, anxiety, depression or nervous system disorder (including Grand mal Epilepsy)?	☐	☐
5. In the past five (5) years, have you filed for or received Disability, Worker's Compensation or State Disability benefits?	☐	☐
If yes, please provide details _____		

7. REPLACEMENT:

	YES	NO
Do you have any existing life insurance or annuities?	☐	☒
Is this application for insurance intended to replace any life insurance or annuities now in force?	☐	☒

(If "YES," submit any special forms required by the state in which the application is signed.)

8. SPECIAL REQUESTS / REMARKS:

9. CONDITIONS RELATING TO THE APPLICATION:

I have read the questions and answers in all parts of this application and agree that they are complete and true to the best of my knowledge and belief. I agree that this application shall form a part of any policy issued. I understand and agree that no agent has the authority to waive a complete answer to any question in the application, pass on insurability, make or alter any contract, or waive any of the Company's other rights or requirements; that any policy applied for shall not take effect (except as provided in the Conditional Receipt bearing the same number as this application) unless and until the policy has been issued and delivered and the full first premium, according to the mode of payment selected by the applicant (as permitted by the Company) and stipulated in the policy, has been paid and accepted by the Company during the lifetime and condition of health of the Proposed Insured as stated in the application.

10. AUTHORIZATION & ACKNOWLEDGMENT:

I authorize any licensed physician, medical practitioner, hospital, clinic, pharmacy benefit manager, other medical or medically related facility, insurance company, the Medical Information Bureau, consumer reporting agency, or other organization, institution or person that has any records or knowledge of me or any proposed insured, to give any such information to Columbian Life Insurance Company ("the Company") or its reinsurers for underwriting or claims purposes. This authorization also includes information about drugs, alcoholism, prescription drug records, or any other medical history information. To facilitate rapid submission of such information, I authorize all said sources, except MIB, to give such records or knowledge to any agency employed by the Company to collect and transmit such information. **I understand** my information may be subject to redisclosure to a third party and may no longer be protected by federal privacy laws. **I understand** a telephone interview may be necessary to verify or supplement information given to the Company on this application. This interview may be made from the Administrative Service Office or from a consumer-reporting agency by a trained interviewer acting on the Company's behalf. A photocopy of this form will be as valid as the original; this authorization will be valid for two (2) years from the date shown below, and will survive my death if it occurs during such two (2) year period. You may revoke this authorization by contacting us at [PO Box 1381 Binghamton, NY 13902-1381] however, we retain the right to use any information obtained under your authorization prior to your revocation. I **have read and understand** the Conditions Relating to the Application and the Authorization & Acknowledgment. I **acknowledge** receipt and review of the Information Practices Relating to Underwriting Your Application. **I have read and acknowledge the applicable fraud notice required by state law.**

[I wish to receive my policy electronically: ☑ **Yes** ☐ **No**
(I understand I would receive a link via email to a secure location for my policy packet.)]

11-16-10
Date of Application

X John Doe 11-16-10
Signature of Proposed Insured (Date)

Dated At (City, State)

X
Signature of Owner (If other than Insured) (Date)

11. REPORT OF LICENSED AGENT:

Does the applicant have any existing life insurance or annuities?	☐ YES	☐ NO
Is this insurance intended to replace, in whole or part, any life insurance or annuities?	☐ YES	☐ NO

(If "YES," submit any special forms required by the state in which the application is signed.)

I hereby affirm that I personally solicited, witnessed, and completed this application and all answers given above are true and correct to the best of my knowledge.

John Smith
Name of Licensed Agent (Print)

X John Smith 11-16-10
Signature of Licensed Agent *(required)* (Date)

12
Agent Number %

Second Agent Number % (If Splitting)

1223
Agent's State License ID No. (in jurisdictions where required)

MISCELLANEOUS — Complete, If Applicable – Not Required In All States

SECONDARY ADDRESSEE / THIRD PARTY DESIGNEE ☑ Not Electing A Secondary Addressee/Third Party At this Time.

(The Applicant/Owner may designate a Secondary Addressee/Third Party to receive a copy of Important Notices.)

Name & Address:

Secondary Addressee / Third Party Authorization

I hereby give permission to accept any Important Notices on behalf of the named Proposed Insured.

X _____

Signature of Secondary Addressee/Third Party (If Required)

REQUEST FOR ELECTRONIC FUNDS TRANSFER PLAN - (Must complete in full) DO NOT USE FOR DRAFT 1st PREMIUM

Amount Paid With Application: $ 0.00

☑ ONE TIME ELECTRONIC FUND TRANSFER

For Electronic Funds Transfer, your agent will submit your application for insurance and this authorization for payment to Columbian Life Insurance Company ("the Company"). By signing this form, you authorize the Company to initiate an electronic funds transfer from your bank account.

Please note that your bank account may be debited the same day your agent submits this authorization. The below hereby authorizes the Company to draw an electronic fund transfer from my bank account for payment of new life insurance.

This will be a **one time withdrawal** from my account in the amount of $ 250.00 from the account detailed below.

Financial Institution: BNA Name of Bank Account Holder: John Doe

Account Type : ☑ Checking or ☐ Savings

Routing Number: 1 1 1 2 2 3 4 5 6 Must have 9 digits in routing no.

Account Number: 2 2 2 3 3 5 6 7 8 1 0 1 1 0 2 9 8 Can have up to 17 positions in account no.

11-16-10 X John Doe

Date **Authorized Signature as it appears on Bank Records (one time withdrawal)**

IF YOU WISH TO CONTINUE MAKING PREMIUM PAYMENTS VIA ELECTRONIC FUNDS TRANSFER, PLEASE COMPLETE THE INFORMATION BELOW AND SIGN. PLEASE NOTE: YOU NEED ONLY INCLUDE THE ACCOUNT INFORMATION IF IT IS DIFFERENT THAN STATED ABOVE.

☐ FIRST DRAFT AND ONGOING ELECTRONIC FUND TRANSFER

I authorize the payment of debits drawn on my account payable to Columbian Life Insurance Company, provided there are sufficient funds in the account. I agree that if any such debit be dishonored, you shall be under no liability in the event the dishonored debit results in forfeiture of insurance.

Any requirement for giving notice of premiums due shall be waived as long as this Electronic Funds Transfer plan is in effect. No premium shall be deemed to have been paid until the Company receives actual payment. The use of this plan shall in no way change the provisions of the policy with respect to the termination of such policy upon nonpayment of the premium due.

This plan shall continue in effect until terminated by the Company or by me by thirty days written notice to the other party. The Company may terminate the EFT plan if any check or electronic fund transfer is not paid on presentation. Upon termination of the Electronic Funds Transfer plan, premiums due under the policy after such termination shall be payable directly to the Company at the minimum modal premium available at the time of issue.

Bank Name _____ ☐ **Checking (Attach voided check if available.)** **or** ☐ **Savings**

Transit / Routing No. ☐☐☐☐☐☐☐☐☐ Must have 9 digits in routing no.

Account No. ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐ Can have up to 17 positions in account no.

[I request withdrawal of payments on: (CHOOSE ONE) Date (1st - 28th)_____ **(OR) Week (1st – 4th)** _____ **/Day (Mon – Fri)** _____

beginning in the month of _____.] X _____

Name of Bank Account Holder John Doe **Date** 11-16-10 **Authorized Signature as it appears on Bank Records (ongoing withdrawals)**

[Please charge $ _____ **to the following card:** ☐ VISA® ☐ MasterCard® ☐ American Express® ☐ Discover® ☐ Debit

Card Number ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐ Security Code (on back of card, 3 digits) ☐☐☐ Card Expiration Date (M/M) – (Y/Y) ☐☐ - ☐☐

_____ X _____

Date Cardholder Name Cardholder Signature]

INFORMATION PRACTICES RELATING TO UNDERWRITING YOUR APPLICATION

Thank you for choosing insurance from Columbian Life Insurance Company. This Notice is given to you at the time you apply for life or health insurance to tell you about the kinds of information we may obtain in connection with your application. **We will treat all personal information about you as confidential.**

INVESTIGATIVE CONSUMER REPORT

We may obtain an investigative consumer report and may tell the consumer reporting agency the amount and type of your coverage. The report may contain data about your identity, age, residence, past and present job (including work duties), economic conditions, driving record, personal and business reputation in the community and mode of living, but will not include any information relating directly or indirectly to sexual orientation.

IDENTIFICATION

To obtain the data described above, the insurer may give my name, address and date and place of birth to the above persons or organizations.

ACCESS TO INFORMATION

You may request, in writing, to receive information from Columbian Life Insurance Company about the nature and scope of an investigative consumer report. Within five (5) business days of receipt of a written request, we will provide you with the name, address and phone number of any agency we ask to prepare such a report. By contacting the investigative agency, you may inspect or receive a copy of such report.

WHERE TO WRITE US

You have a right of access and correction with respect to this information. If you wish a more detailed explanation of our information practices, please send your written request to Underwriting Department, Columbian Life Insurance Company, [PO Box 1381, Binghamton, NY 13902-1381].

MEDICAL INFORMATION BUREAU (MIB), INC. PRE-NOTICE

The Medical Information Bureau is a nonprofit membership organization of life insurance companies. The Bureau provides an information exchange for its members. It maintains information of underwriting significance on policyholders and applicants as furnished to it by member companies. Such information is available only to member companies and only when such company has an authorization signed by you to request such information.

We use the MIB to check information of underwriting significance, but only as a guide to identify areas about which we might need additional information before reaching a final underwriting decision. Columbian Life does not rely, in whole or in part, on an MIB report in making a final underwriting decision.

We make a brief report to the MIB on those individuals about whom we have information about underwriting significance. We will not report what action we have taken on your application. The MIB, on request, supplies other member companies with information in its files if an application for life or health insurance, or a claim for benefits, is submitted to such company. MIB rules require that a member company have our authorization before requesting information about you.

If you question the accuracy of information in the MIB file, you may contact MIB, Inc. and seek a correction in accordance with the procedures set forth in the Federal Fair Credit Reporting Act. The address of the information office of MIB, Inc. is [50 Braintree Hill Park, Suite 400, Braintree, MA 02184-8734, Telephone Number (866) 692-6901 (TTY (866) 346-3642). MIB's website is www.mib.com].

CONDITIONAL RECEIPT

Complete Only When Full Modal Premium Is Received With Application

ALL PREMIUM CHECKS MUST BE MADE PAYABLE TO COLUMBIAN LIFE INSURANCE COMPANY.
DO NOT MAKE CHECKS PAYABLE TO THE AGENT OR LEAVE THE PAYEE BLANK.

Received from (Print) _____ , the sum of _____ on the life of (Proposed Insured) _____ . Columbian Life Insurance Company ("the Company") accepts this payment in connection with your application for insurance and, subject to the terms and conditions of this Conditional Receipt and subject to all the terms and conditions of the policy applied for, agrees to provide coverage under the following conditions:

EFFECTIVE DATE OF COVERAGE: Provided that each of the conditions below is satisfied, coverage under this Conditional Receipt will begin on the later of the Underwriting Date (as defined below) or the specific policy date requested on the application. The Underwriting Date is the later of (1) the date of the application; or (2) the date all underwriting requirements, as required by the Company's underwriting rules, are completed.

CONDITIONS: Insurance coverage under this Conditional Receipt will begin on the Effective Date (as defined above) only if, on that date, all of the following criteria are met:

(1) You had paid the full first modal premium on the policy applied for; and
(2) All Proposed Insureds were insurable at standard rates on the date of the application; and
(3) The Company is able to issue the policy as applied for; and
(4) The amount of insurance applied for, with respect to any Proposed Insured, is not in excess of $500,000.

TERMINATION OF COVERAGE: Any insurance provided under this Conditional Receipt will terminate: (1) Immediately, if the Company refunds your payment or your check was not honored by your Bank; or (2) The date coverage under the policy applied for becomes effective; or (3) Ninety (90) days after the date of the application.

_____ X _____
Date Signature of Licensed Agent

IMPORTANT NOTICE TO THE AGENT: DO NOT SIGN THE CONDITIONAL RECEIPT UNLESS PREMIUM IS TAKEN WITH THE APPLICATION.

FRAUD WARNING STATEMENTS

If the application already includes a fraud warning, the state specific warnings listed below prevail over the standard warning in the application.

The law in **ARKANSAS, LOUISIANA, RHODE ISLAND and WEST VIRGINIA** states: "Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison."

The law in COLORADO states: "It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado division of insurance within the department of regulatory agencies."

The law in **DISTRICT OF COLUMBIA** states: "WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant."

The law in **FLORIDA** states: "Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree."

The law in **KENTUCKY** states: "Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime."

The law in **MARYLAND** states: "ANY PERSON WHO KNOWINGLY AND WILLFULLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT OR WHO KNOWINGLY AND WILLFULLY PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE IS GUILTY OF A CRIME AND MAY BE SUBJECT TO FINES AND CONFINEMENT IN PRISON."

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The law in **OHIO** states: "Any person who, with intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud."

The law in **OKLAHOMA** states: "WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony."

The law in **PENNSYLVANIA** states: "Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concealing any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties."

The law in **TENNESSEE, VIRGINIA and WASHINGTON** states: "It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits."

APPLICATION FOR REINSTATEMENT

COLUMBIAN LIFE INSURANCE COMPANY

HOME OFFICE: CHICAGO, IL
ADMINISTRATIVE SERVICE OFFICE: [P.O. Box 1381, Binghamton, NY 13902-1381]

NAME OF INSURED	POLICY NUMBER	AMOUNT RECEIVED	FOR THE OUTSTANDING PREMIUMS : FROM	THROUGH
John Doe	121	$ 200.00	9-10-10	10-10-10

CURRENT ADDRESS: STREET/RD: Any Street APT #

CITY: City STATE: MO ZIP CODE: 64133 PHONE NUMBER: 816-555-1234

[Please select your preference for receiving correspondence from us: ☐ US Mail ☐ Email *(If you choose Email please make sure you supply your email address.)*] Email Address John@Comcast

I hereby apply for reinstatement of the above numbered policy, subject to its provisions and terms. This application is made on the basis of, and is subject to, the following answers:

HEALTH HISTORY

SECTION A.	YES	NO
1. Are you currently employed? If "NO," please explain. Occupation: manager	☒	☐
2. In the past three (3) years, has any proposed insured:		
▪ Been on probation, parole, been arrested for, convicted or, or pled guilty to any crime or to possession or distribution of drugs or any other illegal substance?	☐	☒
▪ Been convicted of three or more moving violations, been convicted of driving under the influence of alcohol or drugs, or had a driver's license suspended or revoked?	☐	☒
If "YES" to above, please provide details:		
3. Have you used tobacco or any nicotine products in the past twelve (12) months (to include cigarettes, cigars, snuff/chew/dip, pipes, nicotine patch and nicotine gum)?	☐	☒

SECTION B. If "YES" to questions in Sections B or C, please provide details in chart below.	YES	NO
1. Has any proposed insured been diagnosed as having Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC), or Human Immunodeficiency Virus (HIV) Infections (symptomatic or asymptomatic) or been treated for AIDS, ARC, or HIV by a physician or health care provider?	☐	☒
2. Has any proposed insured ever received or been recommended for an organ or bone marrow transplant?	☐	☒
3. Is any proposed insured currently:		
a. Bedridden or confined to any hospital, nursing home, or other medical facility?	☐	☒
b. Using any of the following: walker, wheelchair, electric scooter, oxygen or catheter?	☐	☒
If "YES," please provide details:		
4. Current Height: 6' 1" Current Weight: 190		
Any unexplained history of weight loss of more than 10 lbs. in the last year?	☐	☒
If "YES," please provide details:		
5. In the past three (3) years has any proposed insured:		
a. Engaged in: hang-gliding, cliff diving, scuba diving over 130 feet, parachuting, skydiving, rock or mountain climbing, speeds (in any vehicle) in excess of 100 mph (land or water) or plan such activity in the next 2 years?	☐	☒
b. Flown as a student pilot, or private pilot with over 250 flight hours per year, used an ultra-light aircraft or plan such activity in the next 12 months?	☐	☒

SECTION C.	YES	NO
1. In the past three (3) years, has any proposed insured been declined, postponed, rated or denied reinstatement or asked to pay extra premium by any insurance company?	☐	☒
2. In the past five (5) years, has any proposed insured:		
a. Used cocaine, narcotics, hallucinogens, barbiturates, amphetamines, marijuana or other drugs except as prescribed by a physician?	☐	☒
b. Been advised by a healthcare professional to reduce or stop alcohol or drug use or received treatment for alcohol or drug abuse?	☐	☒
3. Does any proposed insured have or has had a diagnosis of diabetes prior to the age of 35 and/or experienced complications of diabetes, including insulin shock, diabetic coma, Retinopathy (eye), Nephropathy (kidney), Neuropathy (nerve, circulatory) disorder, leg ulcers, amputation or diabetes not under control with current treatments?	☐	☒
4. In the past ten (10) years, has any proposed insured received a diagnosis of or required follow-up for:		
a. Cancer (other than basal cell or squamous cell carcinoma of the skin), leukemia, or lymphoma?	☐	☒
b. Stroke (CVA), transient ischemic attach (TIA), paralysis?	☐	☒
c. Systemic lupus, sarcoidosis, rheumatoid arthritis, Crohn's Disease or ulcerative colitis, degenerative muscle or nerve disease/disorder, immune system or connective tissue disease/disorder?	☐	☒
d. Schizophrenia, bipolar disorder, major depression, mental retardation, Down's Syndrome, Alzheimer's disease, dementia, Parkinson's disease or Multiple Sclerosis?	☐	☒
e. Coronary artery disease, heart attack, coronary bypass surgery (CABG), coronary angioplasty (PTCA), heart valve replacement, angina, heart arrhythmia, congenital heart disease, cardiomyopathy, congestive heart failure (CHF), pacemaker, defibrillator, aneurysm, disease or disorder of the brain, peripheral arteries, blood, liver, pancreas, or kidney (other than kidney stones)?	☐	☒
f. Emphysema, COPD or asthma that has required one or more acute emergency care visits or an inpatient hospitalization?	☐	☒
g. Epilepsy and recurring seizures with the last seizure occurring within the past year?	☐	☒
5. Is any proposed insured awaiting a diagnosis or been advised to have a surgical operation, a diagnostic test or a medical or mental evaluation that has not been completed?	☐	☒
6. In the past five (5) years, has any proposed been prescribed medication or taken any medication prescribed by a physician or been hospitalized or consulted a physician or medical facility for any reason?	☐	☒

TABLE FOR "YES" ANSWERS IN SECTIONS B or C

Person Proposed for Insurance	Medication Name (Copy from Pharmacy Label)	Date last taken	Name & Address of Physician or Medical Facility	Treatment / Diagnosis	Dates & Durations

ANSWER ONLY IF APPLYING FOR REINSTATEMENT OF THE DISABILITY INCOME RIDER

	YES	NO
1. Are you currently covered by Workers Compensation? *(If yes, you are only eligible to apply for an Off-the-Job Disability Income Rider. If so, skip to question #3.)*	☒	☐
2. Occupation Information:		
a. Description of duties _____	☐	☐
b. Have you been working full-time (at least 30 hours per week) for the last 12 months?		
c. If self-employed, % of time working at home? _____		
3. What is the monthly amount of any individual disability insurance you have in force? 1800.00		
4. In the past ten (10) years, have you received care or treatment for, or been diagnosed by a member of the medical profession as having:		
a. Fibromyalgia, Chronic Fatigue Syndrome, Chronic Epstein-Barr, Rheumatoid Arthritis or other inflammatory arthritis?	☐	☒
b. Inflammatory Bowel Disease including Crohn's Disease or Ulcerative Colitis, Diabetes, Skin or Connective Tissue Disorder?	☐	☒
c. Disease or impairment of the spinal column, neck or back, including acute and Chronic neck or back strain; herniated disc syndrome, surgery of the spine or back, acute and chronic sciatica, or congenital disorders of the spinal column and back?	☐	☒
d. Recurring disease or impairment of other bones or joints, e.g. wrist, knee, or shoulder?	☐	☒
e. Any emotional or psychological disorder, including stress, anxiety, depression or nervous system disorder (including Grand mal Epilepsy)?	☐	☒
5. In the past five (5) years, have you filed for or received Disability, Worker's Compensation or State Disability benefits? If yes, please provide details _____	☐	☒

REMARKS:

CONDITIONS RELATING TO THE APPLICATION FOR REINSTATEMENT:

It is understood and agreed that reinstatement shall not be effective unless and until this application is approved by the Company, nor shall it be effective unless all payments required for reinstatement have been paid with the application. The temporary retention of the amount tendered herewith shall not be deemed to effect reinstatement. If reinstatement of the above policy number can not be approved, any premium remitted with this application will be refunded. I have read the answers and statements in this application and agree:

(1) they are complete and correctly recorded to the best of my knowledge and belief and
(2) they shall be the basis upon which the reinstatement will be considered.

To the extent permitted by law, the provisions contained in the policy which relate to incontestability shall run anew from the date of such reinstatement, but only with respect to the statements and answers contained in this application.

AUTHORIZATION AND ACKNOWLEDGMENT:

I authorize any licensed physician, medical practitioner, hospital, clinic, pharmacy benefit manager, other medical or medically related facility, insurance company, the Medical Information Bureau, consumer reporting agency, or other organization, institution or person that has any records or knowledge of me or any proposed insured, to give any such information to Columbian Life Insurance Company ("the Company") or its reinsurers for underwriting or claims purposes. This authorization also includes information about drugs, alcoholism, prescription drug records, or any other medical history information. To facilitate rapid submission of such information, I authorize all said sources, except MIB, to give such records or knowledge to any agency employed by the Company to collect and transmit such information. **I understand** my information may be subject to redisclosure to a third party and may no longer be protected by federal privacy laws. **I understand** a telephone interview may be necessary to verify or supplement information given to the Company on this application. This interview may be made from the Administrative Service Office or from a consumer-reporting agency by a trained interviewer acting on the Company's behalf. A photocopy of this form will be as valid as the original; this authorization will be valid for two (2) years from the date shown below, and will survive my death if it occurs during such two (2) year period. You may revoke this authorization by contacting us at [PO Box 1381 Binghamton, NY 13902-1381] however, we retain the right to use any information obtained under your authorization prior to your revocation. **I have read and understand** the Conditions Relating to the Application and the Authorization & Acknowledgment. **I acknowledge** receipt and review of the Information Practices Relating to Underwriting Your Application.

I understand that a telephone interview may be necessary to verify or supplement information given to the Company on this application for reinstatement. This interview may be made from the Administrative Service Office or from a consumer reporting agency by a trained interviewer acting on the Company's behalf.
Please contact me between the hours of 9 **and** 5.

RECEIPT OF NOTICES

I have read and understand the Conditions Relating to the Application for Reinstatement and the Authorization & Acknowledgment.
I acknowledge receipt of the Information Practices Relating to Underwriting Your Application for Reinstatement.
I have read and acknowledge the applicable fraud notice required by state law.

11-16-10	x John Doe	11-16-10
Date of Application	Signature of Insured	(Date)
City MO	x	
Dated At (City & State)	Signature of Owner (If other than Insured)	(Date)
1212	x John Smith	156
Agent's State License Identification Number (In jurisdictions where required)	Signature of Licensed Agent	Agent Number

REQUEST FOR ELECTRONIC FUNDS TRANSFER PLAN - (Must complete in full)

Bank Name UMB ☐ **Checking (Attach voided check if available.)** **or** ☒ **Savings**

Transit / Routing # 1 2 3 4 5 6 7 8 9 Must have 9 digits in routing #

Account # 1 5 6 8 1 2 7 4 3 1 2 2 5 1 1 2 3 Can have up to 17 positions in account #

I authorize the payment of debits drawn on my account payable to Columbian Life Insurance Company, provided there are sufficient funds in the account. I agree that if any such debit be dishonored, you shall be under no liability in the event the dishonored debit results in forfeiture of insurance.

Any requirement for giving notice of premiums due shall be waived as long as this Electronic Funds Transfer plan is in effect. No premium shall be deemed to have been paid until the Company receives actual payment. The use of this plan shall in no way change the provisions of the policy with respect to the termination of such policy upon nonpayment of the premium due.

This plan shall continue in effect until terminated by the Company or by me by thirty days written notice to the other party. The Company may terminate the EFT plan if any check or electronic fund transfer is not paid on presentation. Upon termination of the Electronic Funds Transfer plan, premiums due under the policy after such termination shall be payable directly to the Company at the minimum modal premium available at the time of issue.

[I request withdrawal of payments on: (CHOOSE ONE) Date (1st - 28th) 15 **(OR) Week (1st – 4th)** _____ **/Day (Mon – Fri)** _____

beginning in the month of _____.]

11-16-10	x John Doe
Date	Authorized Signature as it appears on Bank Records

REINSTATEMENT DEPOSIT RECEIPT COLUMBIAN LIFE INSURANCE COMPANY

NO INSURANCE COVERAGE IS CREATED BY THIS RECEIPT

All premium checks must be made payable to Columbian Life Insurance Company.
Do not make checks payable to the agent or leave the payee blank.

Received from _____ the sum of $ _____ to be retained by the Company while the Reinstatement Application bearing the above number is processed. This is not a conditional receipt and shall have no binding effect on the Company. The Company will refund any money remitted herewith for a policy that is not approved for reinstatement. The Reinstatement Application applies to the policy number: _____.

It is understood and agreed that reinstatement shall not be effective unless and until this application is approved by the Company, nor shall it be effective unless all payments required for reinstatement have been paid with the application. The temporary retention of the amount tendered herewith shall not be deemed to effect reinstatement. If reinstatement cannot be approved, any premium remitted with this application will be refunded.

To the extent permitted by law, the provisions contained in the policy which relate to incontestability shall run anew from the date of such reinstatement, but only with respect to the statements and answers contained in this application.

Date _____ Agent's Signature _____ Agent Number _____

INFORMATION PRACTICES RELATING TO UNDERWRITING YOUR APPLICATION FOR REINSTATEMENT

This Notice is given to you at the time you apply for life insurance to tell you about the kinds of information we may obtain in connection with your application. **We will treat all personal information about you as confidential.**

INVESTIGATIVE CONSUMER REPORT
We may obtain an investigative consumer report and may tell the consumer reporting agency the amount and type of your coverage. The report may contain data about your identity, age, residence, past and present job (including work duties), economic conditions, driving record, personal and business reputation in the community and mode of living, but will not include any information relating directly or indirectly to sexual orientation.

IDENTIFICATION
To obtain the data described above, the insurer may give your name, address and date and place of birth to the above persons or organizations.

ACCESS TO INFORMATION
You may request, in writing, to receive information from Columbian Life Insurance Company about the nature and scope of an investigative consumer report. Within five (5) business days of receipt of a written request, we will provide you with the name, address and phone number of any agency we ask to prepare such a report. By contacting the investigative agency, you may inspect or receive a copy of such report.

WHERE TO WRITE US
You have a right of access and correction with respect to this information. If you wish a more detailed explanation of our information practices, please send your written request to Underwriting Department, Columbian Life Insurance Company, [PO Box 1381 Binghamton, NY 13902-1381].

MEDICAL INFORMATION BUREAU (MIB), INC. PRE-NOTICE
The Medical Information Bureau is a nonprofit membership organization of life insurance companies. The Bureau provides an information exchange for its members. It maintains information of underwriting significance on policyholders and applicants as furnished to it by member companies. Such information is available only to member companies and only when such company has an authorization signed by you to request such information.

We use the MIB to check information of underwriting significance, but only as a guide to identify areas about which we might need additional information before reaching a final underwriting decision. Columbian Life does not rely, in whole or in part, on an MIB report in making a final underwriting decision.

We make a brief report to the MIB on those individuals about whom we have information about underwriting significance. We will not report what action we have taken on your application. The MIB, on request, supplies other member companies with information in its files if an application for life or health insurance, or a claim for benefits, is submitted to such company. MIB rules require that a member company have our authorization before requesting information about you.

If you question the accuracy of information in the MIB file, you may contact MIB, Inc. and seek a correction in accordance with the procedures set forth in the Federal Fair Credit Reporting Act. The address of the information office of MIB, Inc. is [50 Braintree Hill Park, Suite 400, Braintree, MA 02184-8734, Telephone Number (866) 692-6901 (TTY (866) 346-3642). MIB's website is www.mib.com].

FRAUD WARNING STATEMENTS

If the application already includes a fraud warning, the state specific warnings listed below prevail over the standard warning in the application.

The law in **ARKANSAS, LOUISIANA, RHODE ISLAND and WEST VIRGINIA** states: "Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison."

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SERFF Tracking Number:	*FRCS-126995957*	*State:*	*Arkansas*
Filing Company:	*Columbian Life Insurance Company*	*State Tracking Number:*	*47828*
Company Tracking Number:	*5431.7*		
TOI:	*L04I Individual Life - Term*	*Sub-TOI:*	*L04I.500 Other*
Product Name:	*Mortgage Term Life*		
Project Name/Number:	*CML-2/61.7/61.7*		

Supporting Document Schedules

Item Status: **Status Date:**

Satisfied - Item: Flesch Certification
Comments:
Attachments:
AR RDB APP FILING.pdf
AR COC App filing.pdf

Item Status: **Status Date:**

Satisfied - Item: Application
Comments:
Please see the form schedule for the application.

Item Status: **Status Date:**

Satisfied - Item: Authorization
Comments:
Attachment:
AUTH 2011 OCR DISTILLED.pdf

Item Status: **Status Date:**

Satisfied - Item: Mark-up of changes
Comments:
Attachments:
FORM NO. A432-CL _redlined_DISTILLED.pdf
FORM NO. A433-CL _redlined_ DISTILLED.pdf

STATE OF ARKANSAS

READABILITY CERTIFICATION

COMPANY NAME: Columbian Life Insurance Company

This is to certify that the form(s) referenced below has achieved a Flesch Reading Ease Score as indicated below and complies with the requirements of Ark. Stat. Ann. Section 66-3251 through 66-3258, cited as the Life and Disability Insurance Policy Language Simplification Act.

Form Number	Score
FORM NO. A432-CL	*
FORM NO. A433-CL	*

* Scores a 50+ when combined with the policy.

Dorothy M. Klie, FLMI, AIRC
Assistant Vice President, Policy Filing and Assistant Secretary

January 27, 2011
Date

STATE OF ARKANSAS

CERTIFICATION OF COMPLIANCE

Company Name: Columbian Life Insurance Company

Form Titles: Application for Individual Term Life Insurance, Application for Reinstatement

Form Numbers: FORM NO. A432-CL, FORM NO. A433-CL

I hereby certify that to the best of my knowledge and belief, the above form(s) and submission complies with Reg. 19, as well as the other laws and regulations of the State of Arkansas.

Dorothy M. Klie

Dorothy M. Klie, FLMI, AIRC
Assistant Vice President, Policy Filing and Assistant Secretary

January 27, 2011
Date

COLUMBIAN FINANCIAL GROUP

January 7, 2011

To: The Insurance Commissioner

Authorization

This letter, or a copy thereof, will authorize the consulting firm of First Consulting & Administration, Inc., Kansas City, Missouri, to represent this Company in matters before the Insurance Department.

This Authorization shall be valid until revoked by us.

Columbian Life Insurance Company

By: Dorothy M. Klie

Title: Assistant Vice President, Policy Filing and Assistant Secretary

COLUMBIAN MUTUAL LIFE INSURANCE COMPANY • VESTAL PARKWAY EAST • P.O. BOX 1381 • BINGHAMTON, NY 13902-1381
COLUMBIAN LIFE INSURANCE COMPANY • HOME OFFICE: CHICAGO, IL • ADMINISTRATIVE SERVICE OFFICE: BINGHAMTON, NY 13902-1381
www.cfglife.com • (607) 724-2472 ext. 7375 • (607) 722-9952 FAX • Regina.Akulis@cfglife.com

COLUMBIAN LIFE INSURANCE COMPANY

HOME OFFICE: CHICAGO, IL
ADMINISTRATIVE SERVICE OFFICE: [4704 VESTAL PARKWAY EAST
PO Box 1381, Binghamton, NY 13902-1381
(800) 423-9765 / www.cfglife.com]

APPLICATION FOR INDIVIDUAL TERM LIFE INSURANCE POLICY

MAIL POLICY TO: ☐ Agent ☐ Owner

1. PROPOSED INSURED

Name (Last, Middle Initial, First)	Social Security Number	Sex	Age	Date of Birth	State of Birth

Home Address/Apt. No., City, State, Zip Code

Phone Number: ☐ Home ☐ Work ☐ Cell
( )

2. OWNER (Complete only if Owner is other than Proposed Insured.)

Name of Owner	Social Security Number	Relationship to Proposed Insured

Mailing Address/ (If different from Insured)

3. BENEFICIARY

Primary Beneficiary Designation: (Full Name & Relationship to Insured)	Contingent Beneficiary Designation: (Full Name & Relationship to Insured)

4. POLICY INFORMATION

[Please select your preference for receiving correspondence from us: ☐ US Mail ☐ Email
(If you choose Email please make sure you supply your email address.)]

Email Address

PLAN OF INSURANCE:
☐ 15 Year Term ☐ 20 Year Term ☐ 30 Year Term

50% Return of Premium Benefit
☐ 20 Year Term ☐ 30 Year Term

100% Return of Premium Benefit
☐ 20 Year Term ☐ 30 Year

RIDERS:
[☐ Accidental Death Benefit
☐ Waiver of Premium – Disability
☐ Children's Term Insurance Rider
☐ Accelerated Death Benefit – Terminal Illness
☐ Accelerated Death Benefit – Critical Illness
☐ Disability Income Rider
Monthly Benefit _____]

AMOUNT OF INSURANCE (Face Amount):
$_____

AMOUNT PAID WITH APPLICATION:
$_____

Payment Mode: ☐ Annual ☐ Semi-Annual
☐ EFT - Please specify Annual, Semi-Annual or Monthly _____
☐ Draft 1st Premium? (Draft date must be within 30 days of application date. Please see EFT options on Page 4.)

Requested Effective Date:

Children's Rider Amount: _____ Units (Children are natural, step, and legally adopted children.)

Name	Sex	Date of Birth	Height / Weight	Beneficiary
			/	Applies to all Children, including Children added after Issue Date.
			/	
			/	NAME:
			/	
			/	RELATIONSHIP:

5. HEALTH HISTORY

SECTION A.	YES	NO
1. Are all proposed insureds US citizens, permanent US residents or holding a permanent Visa?	☐	☐
2. Are you currently employed? If "NO," please explain _____ Occupation: _____ Annual Income: _____ Total Household Income: _____	☐	☐
3. Have you ~~applied for~~obtained a home mortgage or refinanced an existing mortgage, been married and/or had or adopted a child in the last three (3) years? (If "NO," do not continue.)	☐	☐
4. Do you have a Driver's License? If "NO," please provide details: _____ If "YES," Driver's License No. and State: _____	☐	☐
5. In the past three (3) years, ~~have you~~has any proposed insured: ▪ Been on probation, parole, been arrested for, convicted or, or pled guilty to any crime or to possession or distribution of drugs or any other illegal substance?	☐	☐
▪ Been convicted of three or more moving violations, been convicted of driving under the influence of alcohol or drugs, or had a driver's license suspended or revoked?	☐	☐
If "YES" to above, please provide details: _____		
6. Have you used tobacco or any nicotine products in the past twelve (12) months (to include cigarettes, cigars, snuff/chew/dip, pipes, nicotine patch and nicotine gum)?	☐	☐

SECTION B. If "YES" to questions in Sections B or C, please provide details in chart below. YES NO

1. ~~Have you~~Has any proposed insured been diagnosed as having Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC), or Human Immunodeficiency Virus (HIV) Infections (symptomatic or asymptomatic) or been treated for AIDS, ARC, or HIV by a physician or health care provider? ☐ ☐
2. ~~Have you~~Has any proposed insured ever received or been recommended for an organ or bone marrow transplant? ☐ ☐
3. ~~Are you~~Is any proposed insured currently:
   a. Bedridden or confined to any hospital, nursing home, or other medical facility? ☐ ☐
   b. Using any of the following: walker, wheelchair, electric scooter, oxygen or catheter? ☐ ☐
   If "YES," please provide details: _____
4. Current Height: _____ Current Weight: _____
   Any unexplained history of weight loss ~~or~~ of more than 10 lbs. in the last year? ☐ ☐
   If "YES," please provide details: _____
5. In the past three (3) years ~~have you~~has any proposed insured:
   a. Engaged in: hang-gliding, cliff diving, scuba diving over 130 feet, parachuting, skydiving, rock or mountain climbing, speeds (in any vehicle) in excess of 100 mph (land or water) or plan such activity in the next 2 years? ☐ ☐
   b. Flown as a student pilot, or private pilot with over 250 flight hours per year, used an ultra-light aircraft or plan such activity in the next 12 months? ☐ ☐

SECTION C ~~If "YES" to questions 1-6 in this section, please provide details in chart below.~~ YES NO

1. In the past three (3) years, ~~have you~~has any proposed insured ~~ever~~ been declined, postponed, rated or denied reinstatement or asked to pay extra premium by any insurance company? ☐ ☐
2. In the past five (5) years, ~~have you~~has any proposed insured:
   a. Used cocaine, narcotics, hallucinogens, barbiturates, amphetamines, marijuana or other drugs except as prescribed by a physician? ☐ ☐
   b. Been advised by a healthcare professional to reduce or stop alcohol or drug use or received treatment for alcohol or drug abuse? ☐ ☐
3. ~~Do you~~Does any proposed insured have or has had a diagnosis of diabetes prior to the age of 35 and/or experienced complications of diabetes, including insulin shock, diabetic coma, Retinopathy (eye), Nephropathy (kidney), Neuropathy (nerve, circulatory) disorder, leg ulcers, amputation or diabetes not under control with current treatments? ☐ ☐
4. In the past ten (10) years, ~~have you~~has any proposed insured received a diagnosis of or required follow-up for:
   a. Cancer (other than basal cell or squamous cell carcinoma of the skin), leukemia, or lymphoma? ☐ ☐
   b. Stroke (CVA), transient ischemic attach (TIA), paralysis? ☐ ☐
   c. Systemic lupus, sarcoidosis, rheumatoid arthritis, Crohn's Disease or ulcerative colitis, degenerative muscle or nerve disease/disorder, immune system or connective tissue disease/disorder? ☐ ☐
   d. Schizophrenia, bipolar disorder, major depression, mental retardation, Down's Syndrome, Alzheimer's disease, dementia, Parkinson's disease or Multiple Sclerosis? ☐ ☐
   e. Coronary artery disease, heart attack, coronary bypass surgery (CABG), coronary angioplasty (PTCA), heart valve replacement, angina, heart arrhythmia, congenital heart disease, cardiomyopathy, congestive heart failure (CHF), pacemaker, defibrillator, aneurysm, disease or disorder of the brain, peripheral arteries, blood, liver, pancreas, or kidney (other than kidney stones)? ☐ ☐
   f. Emphysema, COPD or asthma that has required one or more acute emergency care visits or an inpatient hospitalization? ☐ ☐
   g. Epilepsy and recurring seizures with the last seizure occurring within the past year? ☐ ☐
5. ~~Are you~~Is any proposed insured awaiting a diagnosis or been advised to have a surgical operation, a diagnostic test or a medical or mental evaluation that has not been completed? ☐ ☐
6. In the past five (5) years, ~~have you~~has any proposed insured been prescribed medication or taken any medication prescribed by a physician or been hospitalized or consulted a physician or medical facility for any reason? ☐ ☐

TABLE FOR "YES" ANSWERS IN SECTIONS B OR C ~~QUESTIONS 1-6~~

Person Proposed for Insurance	Medication Name (Copy from Pharmacy Label)	Date last taken	Name & Address of Physician or Medical Facility	Treatment / Diagnosis	Dates & Durations

6. ANSWER ONLY IF APPLYING FOR THE DISABILITY INCOME RIDER YES NO

1. Are you currently covered by Workers Compensation? ☐ ☐
   (If yes, you are only eligible to apply for an Off-the-Job Disability Income Rider. If so, skip to question #3.)
2. Occupation Information:
   a. Description of duties _____
   b. Have you been working full-time (at least 30 hours per week) for the last 12 months? ☐ ☐
   c. If self-employed, % of time working at home? _____
3. What is the monthly amount of any individual disability insurance you have in force? _____
4. In the past ten (10) years, have you received care or treatment for, or been diagnosed by a member of the medical profession as having:
   a. Fibromyalgia, Chronic Fatigue Syndrome, Chronic Epstein-Barr, Rheumatoid Arthritis or other inflammatory arthritis? ☐ ☐
   b. Inflammatory Bowel Disease including Crohn's Disease or Ulcerative Colitis, Diabetes, Skin or Connective Tissue Disorder? ☐ ☐
   c. Disease or impairment of the spinal column, neck or back, including acute and Chronic neck or back strain; herniated disc syndrome, surgery of the spine or back, acute and chronic sciatica, or congenital disorders of the spinal column and back? ☐ ☐
   d. Recurring disease or impairment of other bones or joints, e.g. wrist, knee, or shoulder? ☐ ☐
   e. Any emotional or psychological disorder, including stress, anxiety, depression or nervous system disorder (including Grand mal Epilepsy)? ☐ ☐
5. In the past five (5) years, have you filed for or received Disability, Worker's Compensation or State Disability benefits? ☐ ☐
   If yes, please provide details _____

7. REPLACEMENT:

	YES	NO
Do you have any existing life insurance or annuities?……	☐	☐
Is this application for insurance intended to replace any life insurance or annuities now in force?……	☐	☐

(If "YES," submit any special forms required by the state in which the application is signed.)

8. SPECIAL REQUESTS / REMARKS:

9. CONDITIONS RELATING TO THE APPLICATION:

I have read the questions and answers in all parts of this application and agree that they are complete and true to the best of my knowledge and belief. I agree that this application shall form a part of any policy issued. I understand and agree that no agent has the authority to waive a complete answer to any question in the application, pass on insurability, make or alter any contract, or waive any of the Company's other rights or requirements; that any policy applied for shall not take effect (except as provided in the Conditional Receipt bearing the same number as this application) unless and until the policy has been issued and delivered and the full first premium, according to the mode of payment selected by the applicant (as permitted by the Company) and stipulated in the policy, has been paid and accepted by the Company during the lifetime and condition of health of the Proposed Insured as stated in the application.

10. AUTHORIZATION & ACKNOWLEDGMENT:

I authorize any licensed physician, medical practitioner, hospital, clinic, pharmacy benefit manager, other medical or medically related facility, insurance company, the Medical Information Bureau, consumer reporting agency, or other organization, institution or person that has any records or knowledge of me or any proposed insured, to give any such information to Columbian Life Insurance Company ("the Company") or its reinsurers for underwriting or claims purposes. This authorization also includes information about drugs, alcoholism, prescription drug records, or any other medical history information. To facilitate rapid submission of such information, I authorize all said sources, except MIB, to give such records or knowledge to any agency employed by the Company to collect and transmit such information. I understand my information may be subject to redisclosure to a third party and may no longer be protected by federal privacy laws. I understand a telephone interview may be necessary to verify or supplement information given to the Company on this application. This interview may be made from the Administrative Service Office or from a consumer-reporting agency by a trained interviewer acting on the Company's behalf. A photocopy of this form will be as valid as the original; this authorization will be valid for two (2) years from the date shown below, and will survive my death if it occurs during such two (2) year period. You may revoke this authorization by contacting us at [PO Box 1381 Binghamton, NY 13902-1381] however, we retain the right to use any information obtained under your authorization prior to your revocation. I have read and understand the Conditions Relating to the Application and the Authorization & Acknowledgment. I acknowledge receipt and review of the Information Practices Relating to Underwriting Your Application. I have read and acknowledge the applicable fraud notice required by state law.

[I wish to receive my policy electronically: ☐ Yes ☐ No
(I understand I would receive a link via email to a secure location for my policy packet.)]

_____ X _____
Date of Application — Signature of Proposed Insured ~~(Parent/Guardian if 15 or under)~~ (Date)

_____ X _____
Dated At (City, State) — Signature of Owner (If other than Insured) (Date)

11. REPORT OF LICENSED AGENT:

Does the applicant have any existing life insurance or annuities?……	☐ YES	☐ NO
Is this insurance intended to replace, in whole or part, any life insurance or annuities?……	☐ YES	☐ NO

(If "YES," submit any special forms required by the state in which the application is signed.)

~~HAS THE TELEPHONE INTERVIEW BEEN COMPLETED? …… ☐ YES ☐ NO~~

I hereby affirm that I personally solicited, witnessed, and completed this application and all answers given above are true and correct to the best of my knowledge.

_____ X _____
Name of Licensed Agent (Print) — Signature of Licensed Agent *(required)* (Date)

_____ _____ _____
Agent Number % — Second Agent Number % (If Splitting) — Agent's State License ID No. (in jurisdictions where required)

MISCELLANEOUS — Complete, If Applicable – Not Required In All States

SECONDARY ADDRESSEE / THIRD PARTY DESIGNEE ☐ Not Electing A Secondary Addressee/Third Party At this Time.

(The Applicant/Owner may designate a Secondary Addressee/Third Party to receive a copy of Important Notices.)

Name & Address:

Secondary Addressee / Third Party Authorization

I hereby give permission to accept any Important Notices on behalf of the named Proposed Insured.

X _____

Signature of Secondary Addressee/Third Party (If Required)

REQUEST FOR ELECTRONIC FUNDS TRANSFER PLAN - (Must complete in full) DO NOT USE FOR DRAFT 1st PREMIUM

Amount Paid With Application: $_____

☐ ONE TIME ELECTRONIC FUND TRANSFER

For Electronic Funds Transfer, your agent will submit your application for insurance and this authorization for payment to Columbian Life Insurance Company ("the Company"). By signing this form, you authorize the Company to initiate an electronic funds transfer from your bank account.

Please note that your bank account may be debited the same day your agent submits this authorization. The below hereby authorizes the Company to draw an electronic fund transfer from my bank account for payment of new life insurance.

This will be a **one time withdrawal** from my account in the amount of $ _____ from the account detailed below.

Financial Institution: _____ Name of Bank Account Holder: _____

Account Type : ☐ Checking or ☐ Savings

Routing Number: ☐☐☐☐☐☐☐☐☐ Must have 9 digits in routing no.

Account Number: ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐ Can have up to 17 positions in account no.

_____ **X** _____

Date — Authorized Signature as it appears on Bank Records (one time withdrawal)

IF YOU WISH TO CONTINUE MAKING PREMIUM PAYMENTS VIA ELECTRONIC FUNDS TRANSFER, PLEASE COMPLETE THE INFORMATION BELOW AND SIGN. PLEASE NOTE: YOU NEED ONLY INCLUDE THE ACCOUNT INFORMATION IF IT IS DIFFERENT THAN STATED ABOVE.

☐ FIRST DRAFT AND ONGOING ELECTRONIC FUND TRANSFER

I authorize the payment of debits drawn on my account payable to Columbian Life Insurance Company, provided there are sufficient funds in the account. I agree that if any such debit be dishonored, you shall be under no liability in the event the dishonored debit results in forfeiture of insurance.

Any requirement for giving notice of premiums due shall be waived as long as this Electronic Funds Transfer plan is in effect. No premium shall be deemed to have been paid until the Company receives actual payment. The use of this plan shall in no way change the provisions of the policy with respect to the termination of such policy upon nonpayment of the premium due.

This plan shall continue in effect until terminated by the Company or by me by thirty days written notice to the other party. The Company may terminate the EFT plan if any check or electronic fund transfer is not paid on presentation. Upon termination of the Electronic Funds Transfer plan, premiums due under the policy after such termination shall be payable directly to the Company at the minimum modal premium available at the time of issue.

Bank Name _____ ☐ Checking (Attach voided check if available.) or ☐ Savings

Transit / Routing No. ☐☐☐☐☐☐☐☐☐ Must have 9 digits in routing no.

Account No. ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐ Can have up to 17 positions in account no.

[I request withdrawal of payments on: (CHOOSE ONE) Date (1st - 28th)_____ (OR) Week (1st – 4th) _____ /Day (Mon – Fri) _____

beginning in the month of _____ .] X _____

Name of Bank Account Holder — Date — Authorized Signature as it appears on Bank Records (ongoing withdrawals)

[Please charge $ _____ to the following card: ☐ VISA® ☐ MasterCard® ☐ American Express® ☐ Discover® ☐ Debit

Card Number ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐ Security Code (on back of card, 3 digits) ☐☐☐ Card Expiration Date (M/M) – (Y/Y) ☐☐ - ☐☐

_____ X _____

Date — Cardholder Name — Cardholder Signature]

INFORMATION PRACTICES RELATING TO UNDERWRITING YOUR APPLICATION

Thank you for choosing insurance from Columbian Life Insurance Company. This Notice is given to you at the time you apply for life or health insurance to tell you about the kinds of information we may obtain in connection with your application. We will treat all personal information about you as confidential.

INVESTIGATIVE CONSUMER REPORT
We may obtain an investigative consumer report and may tell the consumer reporting agency the amount and type of your coverage. The report may contain data about your identity, age, residence, past and present job (including work duties), economic conditions, driving record, personal and business reputation in the community and mode of living, but will not include any information relating directly or indirectly to sexual orientation.

IDENTIFICATION
To obtain the data described above, the insurer may give my name, address and date and place of birth to the above persons or organizations.

ACCESS TO INFORMATION
You may request, in writing, to receive information from Columbian Life Insurance Company about the nature and scope of an investigative consumer report. Within five (5) business days of receipt of a written request, we will provide you with the name, address and phone number of any agency we ask to prepare such a report. By contacting the investigative agency, you may inspect or receive a copy of such report.

WHERE TO WRITE US
You have a right of access and correction with respect to this information. If you wish a more detailed explanation of our information practices, please send your written request to Underwriting Department, Columbian Life Insurance Company, [PO Box 1381, Binghamton, NY 13902-1381].

MEDICAL INFORMATION BUREAU (MIB), INC. PRE-NOTICE
The Medical Information Bureau is a nonprofit membership organization of life insurance companies. The Bureau provides an information exchange for its members. It maintains information of underwriting significance on policyholders and applicants as furnished to it by member companies. Such information is available only to member companies and only when such company has an authorization signed by you to request such information.

We use the MIB to check information of underwriting significance, but only as a guide to identify areas about which we might need additional information before reaching a final underwriting decision. Columbian Life does not rely, in whole or in part, on an MIB report in making a final underwriting decision.

We make a brief report to the MIB on those individuals about whom we have information about underwriting significance. We will not report what action we have taken on your application. The MIB, on request, supplies other member companies with information in its files if an application for life or health insurance, or a claim for benefits, is submitted to such company. MIB rules require that a member company have our authorization before requesting information about you.

If you question the accuracy of information in the MIB file, you may contact MIB, Inc. and seek a correction in accordance with the procedures set forth in the Federal Fair Credit Reporting Act. The address of the information office of MIB, Inc. is [50 Braintree Hill Park, Suite 400, Braintree, MA 02184-8734, Telephone Number (866) 692-6901 (TTY (866) 346-3642). MIB's website is www.mib.com].

CONDITIONAL RECEIPT

Complete Only When Full Modal Premium Is Received With Application

ALL PREMIUM CHECKS MUST BE MADE PAYABLE TO COLUMBIAN LIFE INSURANCE COMPANY.
DO NOT MAKE CHECKS PAYABLE TO THE AGENT OR LEAVE THE PAYEE BLANK.

Received from (Print) _____, the sum of_____ on the life of (Proposed Insured) _____ _ . Columbian Life Insurance Company ("the Company") accepts this payment in connection with your application for insurance and, subject to the terms and conditions of this Conditional Receipt and subject to all the terms and conditions of the policy applied for, agrees to provide coverage under the following conditions:

EFFECTIVE DATE OF COVERAGE: Provided that each of the conditions below is satisfied, coverage under this Conditional Receipt will begin on the later of the Underwriting Date (as defined below) or the specific policy date requested on the application. The Underwriting Date is the later of (1) the date of the application; or (2) the date all underwriting requirements, as required by the Company's underwriting rules, are completed.

CONDITIONS: Insurance coverage under this Conditional Receipt will begin on the Effective Date (as defined above) only if, on that date, all of the following criteria are met:

(1) You had paid the full first modal premium on the policy applied for; and
(2) All Proposed Insureds were insurable at standard rates on the date of the application; and
(3) The Company is able to issue the policy as applied for; and
(4) The amount of insurance applied for, with respect to any Proposed Insured, is not in excess of $500,000.

TERMINATION OF COVERAGE: Any insurance provided under this Conditional Receipt will terminate: (1) Immediately, if the Company refunds your payment or your check was not honored by your Bank; or (2) The date coverage under the policy applied for becomes effective; or (3) Ninety (90) days after the date of the application.

_____ X_____
Date Signature of Licensed Agent

IMPORTANT NOTICE TO THE AGENT: DO NOT SIGN THE CONDITIONAL RECEIPT UNLESS PREMIUM IS TAKEN WITH THE APPLICATION.

FRAUD WARNING STATEMENTS

If the application already includes a fraud warning, the state specific warnings listed below prevail over the standard warning in the application.

The law in **ARKANSAS, LOUISIANA, RHODE ISLAND and WEST VIRGINIA** states: "Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison."

The law in COLORADO states: "It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado division of insurance within the department of regulatory agencies."

The law in **DISTRICT OF COLUMBIA** states: "WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant."

The law in **FLORIDA** states: "Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree."

The law in **KENTUCKY** states: "Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime."

The law in **MARYLAND** states: "ANY PERSON WHO KNOWINGLY AND WILLFULLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT OR WHO KNOWINGLY AND WILLFULLY PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE IS GUILTY OF A CRIME AND MAY BE SUBJECT TO FINES AND CONFINEMENT IN PRISON."

The law in **NEW JERSEY** states: "Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties."

The law in **NEW MEXICO** states: "ANY PERSON WHO KNOWINGLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT OR KNOWINGLY PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE IS GUILTY OF A CRIME AND MAY BE SUBJECT TO CIVIL FINES AND CRIMINAL PENALTIES."

The law in **OHIO** states: "Any person who, with intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud."

The law in **OKLAHOMA** states: "WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony."

The law in **PENNSYLVANIA** states: "Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concealing any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties."

The law in **TENNESSEE, VIRGINIA and WASHINGTON** states: "It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits."

APPLICATION FOR REINSTATEMENT

COLUMBIAN LIFE INSURANCE COMPANY

HOME OFFICE: CHICAGO, IL
ADMINISTRATIVE SERVICE OFFICE: [P.O. Box 1381, Binghamton, NY 13902-1381]

NAME OF INSURED	POLICY NUMBER	AMOUNT RECEIVED	FOR THE OUTSTANDING PREMIUMS : FROM	THROUGH
		$		

CURRENT ADDRESS: STREET/RD: APT #

CITY: STATE: ZIP CODE: PHONE NUMBER:

[Please select your preference for receiving correspondence from us: ☐ US Mail ☐ Email *(If you choose Email please make sure you supply your email address.)*] Email Address

I hereby apply for reinstatement of the above numbered policy, subject to its provisions and terms. This application is made on the basis of, and is subject to, the following answers:

HEALTH HISTORY

SECTION A.	YES	NO
1. Are you currently employed? If "NO," please explain._____ Occupation: _____	☐	☐
2. In the past three (3) years, ~~have you~~has any proposed insured:		
▪ Been on probation, parole, been arrested for, convicted or, or pled guilty to any crime or to possession or distribution of drugs or any other illegal substance?	☐	☐
▪ Been convicted of three or more moving violations, been convicted of driving under the influence of alcohol or drugs, or had a driver's license suspended or revoked?	☐	☐
If "YES" to above, please provide details: _____		
3. Have you used tobacco or any nicotine products in the past twelve (12) months (to include cigarettes, cigars, snuff/chew/dip, pipes, nicotine patch and nicotine gum)?	☐	☐

SECTION B. If "YES" to questions in Sections B or C, please provide details in chart below.	YES	NO
1. ~~Have you~~Has any proposed insured been diagnosed as having Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC), or Human Immunodeficiency Virus (HIV) Infections (symptomatic or asymptomatic) or been treated for AIDS, ARC, or HIV by a physician or health care provider?	☐	☐
2. ~~Have you~~Has any proposed insured ever received or been recommended for an organ or bone marrow transplant?	☐	☐
3. ~~Are you~~Is any proposed insured currently:		
a. Bedridden or confined to any hospital, nursing home, or other medical facility?	☐	☐
b. Using any of the following: walker, wheelchair, electric scooter, oxygen or catheter?	☐	☐
If "YES," please provide details: _____		
4. Current Height: _____ Current Weight: _____ Any unexplained history of weight loss ~~or~~ of more than 10 lbs. in the last year? If "YES," please provide details: _____	☐	☐
5. In the past three (3) years ~~have you~~has any proposed insured:		
a. Engaged in: hang-gliding, cliff diving, scuba diving over 130 feet, parachuting, skydiving, rock or mountain climbing, speeds (in any vehicle) in excess of 100 mph (land or water) or plan such activity in the next 2 years?	☐	☐
b. Flown as a student pilot, or private pilot with over 250 flight hours per year, used an ultra-light aircraft or plan such activity in the next 12 months?	☐	☐

SECTION C. ~~If "YES" to questions 1-6 in this section, please provide details in chart below.~~	YES	NO
1. In the past three (3) years, ~~have you ever~~has any proposed insured been declined, postponed, rated or denied reinstatement or asked to pay extra premium by any insurance company?	☐	☐
2. In the past five (5) years, ~~have you~~has any proposed insured:		
a. Used cocaine, narcotics, hallucinogens, barbiturates, amphetamines, marijuana or other drugs except as prescribed by a physician?	☐	☐
b. Been advised by a healthcare professional to reduce or stop alcohol or drug use or received treatment for alcohol or drug abuse?	☐	☐
3. ~~Do you~~Does any proposed insured have or has had a diagnosis of diabetes prior to the age of 35 and/or experienced complications of diabetes, including insulin shock, diabetic coma, Retinopathy (eye), Nephropathy (kidney), Neuropathy (nerve, circulatory) disorder, leg ulcers, amputation or diabetes not under control with current treatments?	☐	☐
4. In the past ten (10) years, ~~have you~~has any proposed insured received a diagnosis of or required follow-up for:		
a. Cancer (other than basal cell or squamous cell carcinoma of the skin), leukemia, or lymphoma?	☐	☐
b. Stroke (CVA), transient ischemic attach (TIA), paralysis?	☐	☐
c. Systemic lupus, sarcoidosis, rheumatoid arthritis, Crohn's Disease or ulcerative colitis, degenerative muscle or nerve disease/disorder, immune system or connective tissue disease/disorder?	☐	☐
d. Schizophrenia, bipolar disorder, major depression, mental retardation, Down's Syndrome, Alzheimer's disease, dementia, Parkinson's disease or Multiple Sclerosis?	☐	☐
e. Coronary artery disease, heart attack, coronary bypass surgery (CABG), coronary angioplasty (PTCA), heart valve replacement, angina, heart arrhythmia, congenital heart disease, cardiomyopathy, congestive heart failure (CHF), pacemaker, defibrillator, aneurysm, disease or disorder of the brain, peripheral arteries, blood, liver, pancreas, or kidney (other than kidney stones)?	☐	☐
f. Emphysema, COPD or asthma that has required one or more acute emergency care visits or an inpatient hospitalization?	☐	☐
g. Epilepsy and recurring seizures with the last seizure occurring within the past year?	☐	☐
5. ~~Are you~~Is any proposed insured awaiting a diagnosis or been advised to have a surgical operation, a diagnostic test or a medical or mental evaluation that has not been completed?	☐	☐
6. In the past five (5) years, ~~have you~~has any proposed been prescribed medication or taken any medication prescribed by a physician or been hospitalized or consulted a physician or medical facility for any reason?	☐	☐

TABLE FOR "YES" ANSWERS IN SECTIONS B or C ~~QUESTIONS 1-6~~

Person Proposed for Insurance	Medication Name (Copy from Pharmacy Label)	Date last taken	Name & Address of Physician or Medical Facility	Treatment / Diagnosis	Dates & Durations

ANSWER ONLY IF APPLYING FOR REINSTATEMENT OF THE DISABILITY INCOME RIDER

	YES	NO
1. Are you currently covered by Workers Compensation? *(If yes, you are only eligible to apply for an Off-the-Job Disability Income Rider. If so, skip to question #3.)*	☐	☐
2. Occupation Information:		
a. Description of duties _____	☐	☐
b. Have you been working full-time (at least 30 hours per week) for the last 12 months?		
c. If self-employed, % of time working at home? _____		
3. What is the monthly amount of any individual disability insurance you have in force? _____		
4. In the past ten (10) years, have you received care or treatment for, or been diagnosed by a member of the medical profession as having:		
a. Fibromyalgia, Chronic Fatigue Syndrome, Chronic Epstein-Barr, Rheumatoid Arthritis or other inflammatory arthritis?	☐	☐
b. Inflammatory Bowel Disease including Crohn's Disease or Ulcerative Colitis, Diabetes, Skin or Connective Tissue Disorder?	☐	☐
c. Disease or impairment of the spinal column, neck or back, including acute and Chronic neck or back strain; herniated disc syndrome, surgery of the spine or back, acute and chronic sciatica, or congenital disorders of the spinal column and back?	☐	☐
d. Recurring disease or impairment of other bones or joints, e.g. wrist, knee, or shoulder?	☐	☐
e. Any emotional or psychological disorder, including stress, anxiety, depression or nervous system disorder (including Grand mal Epilepsy)?	☐	☐
5. In the past five (5) years, have you filed for or received Disability, Worker's Compensation or State Disability benefits? If yes, please provide details _____	☐	☐

REMARKS:

CONDITIONS RELATING TO THE APPLICATION FOR REINSTATEMENT:

It is understood and agreed that reinstatement shall not be effective unless and until this application is approved by the Company, nor shall it be effective unless all payments required for reinstatement have been paid with the application. The temporary retention of the amount tendered herewith shall not be deemed to effect reinstatement. If reinstatement of the above policy number can not be approved, any premium remitted with this application will be refunded. I have read the answers and statements in this application and agree:

(1) they are complete and correctly recorded to the best of my knowledge and belief and
(2) they shall be the basis upon which the reinstatement will be considered.

To the extent permitted by law, the provisions contained in the policy which relate to incontestability shall run anew from the date of such reinstatement, but only with respect to the statements and answers contained in this application.

AUTHORIZATION AND ACKNOWLEDGMENT:

I authorize any licensed physician, medical practitioner, hospital, clinic, pharmacy benefit manager, other medical or medically related facility, insurance company, the Medical Information Bureau, consumer reporting agency, or other organization, institution or person that has any records or knowledge of me or any proposed insured, to give any such information to Columbian Life Insurance Company ("the Company") or its reinsurers for underwriting or claims purposes. This authorization also includes information about drugs, alcoholism, prescription drug records, or any other medical history information. To facilitate rapid submission of such information, I authorize all said sources, except MIB, to give such records or knowledge to any agency employed by the Company to collect and transmit such information. I understand my information may be subject to redisclosure to a third party and may no longer be protected by federal privacy laws. I understand a telephone interview may be necessary to verify or supplement information given to the Company on this application. This interview may be made from the Administrative Service Office or from a consumer-reporting agency by a trained interviewer acting on the Company's behalf. A photocopy of this form will be as valid as the original; this authorization will be valid for two (2) years from the date shown below, and will survive my death if it occurs during such two (2) year period. You may revoke this authorization by contacting us at [PO Box 1381 Binghamton, NY 13902-1381] however, we retain the right to use any information obtained under your authorization prior to your revocation. I have read and understand the Conditions Relating to the Application and the Authorization & Acknowledgment. I acknowledge receipt and review of the Information Practices Relating to Underwriting Your Application.

I understand that a telephone interview may be necessary to verify or supplement information given to the Company on this application for reinstatement. This interview may be made from the Administrative Service Office or from a consumer reporting agency by a trained interviewer acting on the Company's behalf.
Please contact me between the hours of _____ and _____.

RECEIPT OF NOTICES

I have read and understand the Conditions Relating to the Application for Reinstatement and the Authorization & Acknowledgment.
I acknowledge receipt of the Information Practices Relating to Underwriting Your Application for Reinstatement.
I have read and acknowledge the applicable fraud notice required by state law.

_____ X _____
Date of Application — Signature of Insured ~~(Parent/Guardian if 15 or under)~~ (Date)

_____ X _____
Dated At (City & State) — Signature of Owner (If other than Insured) (Date)

_____ X _____
Agent's State License Identification Number (In jurisdictions where required) — Signature of Licensed Agent — Agent Number

REQUEST FOR ELECTRONIC FUNDS TRANSFER PLAN - (Must complete in full)

Bank Name _____ ☐ Checking (Attach voided check if available.) or ☐ Savings

Transit / Routing # | | | | | | | | | | Must have 9 digits in routing #

Account # | | | | | | | | | | | | | | | | | Can have up to 17 positions in account #

I authorize the payment of debits drawn on my account payable to Columbian Life Insurance Company, provided there are sufficient funds in the account. I agree that if any such debit be dishonored, you shall be under no liability in the event the dishonored debit results in forfeiture of insurance.

Any requirement for giving notice of premiums due shall be waived as long as this Electronic Funds Transfer plan is in effect. No premium shall be deemed to have been paid until the Company receives actual payment. The use of this plan shall in no way change the provisions of the policy with respect to the termination of such policy upon nonpayment of the premium due.

This plan shall continue in effect until terminated by the Company or by me by thirty days written notice to the other party. The Company may terminate the EFT plan if any check or electronic fund transfer is not paid on presentation. Upon termination of the Electronic Funds Transfer plan, premiums due under the policy after such termination shall be payable directly to the Company at the minimum modal premium available at the time of issue.
[I request withdrawal of payments on: (CHOOSE ONE) Date (1st - 28th)_____ (OR) Week (1st – 4th) _____ /Day (Mon – Fri) _____
beginning in the month of _____.] _____ X _____
Date — Authorized Signature as it appears on Bank Records

REINSTATEMENT DEPOSIT RECEIPT COLUMBIAN LIFE INSURANCE COMPANY

NO INSURANCE COVERAGE IS CREATED BY THIS RECEIPT

All premium checks must be made payable to Columbian Life Insurance Company.
Do not make checks payable to the agent or leave the payee blank.

Received from _____ the sum of $ _____ to be retained by the Company while the Reinstatement Application bearing the above number is processed. This is not a conditional receipt and shall have no binding effect on the Company. The Company will refund any money remitted herewith for a policy that is not approved for reinstatement. The Reinstatement Application applies to the policy number: _____.

It is understood and agreed that reinstatement shall not be effective unless and until this application is approved by the Company, nor shall it be effective unless all payments required for reinstatement have been paid with the application. The temporary retention of the amount tendered herewith shall not be deemed to effect reinstatement. If reinstatement cannot be approved, any premium remitted with this application will be refunded.

To the extent permitted by law, the provisions contained in the policy which relate to incontestability shall run anew from the date of such reinstatement, but only with respect to the statements and answers contained in this application.

Date _____ Agent's Signature _____ Agent Number _____

INFORMATION PRACTICES RELATING TO UNDERWRITING YOUR APPLICATION FOR REINSTATEMENT

This Notice is given to you at the time you apply for life insurance to tell you about the kinds of information we may obtain in connection with your application. We will treat all personal information about you as confidential.

INVESTIGATIVE CONSUMER REPORT

We may obtain an investigative consumer report and may tell the consumer reporting agency the amount and type of your coverage. The report may contain data about your identity, age, residence, past and present job (including work duties), economic conditions, driving record, personal and business reputation in the community and mode of living, but will not include any information relating directly or indirectly to sexual orientation.

IDENTIFICATION

To obtain the data described above, the insurer may give your name, address and date and place of birth to the above persons or organizations.

ACCESS TO INFORMATION

You may request, in writing, to receive information from Columbian Life Insurance Company about the nature and scope of an investigative consumer report. Within five (5) business days of receipt of a written request, we will provide you with the name, address and phone number of any agency we ask to prepare such a report. By contacting the investigative agency, you may inspect or receive a copy of such report.

WHERE TO WRITE US

You have a right of access and correction with respect to this information. If you wish a more detailed explanation of our information practices, please send your written request to Underwriting Department, Columbian Life Insurance Company, [PO Box 1381 Binghamton, NY 13902-1381].

MEDICAL INFORMATION BUREAU (MIB), INC. PRE-NOTICE

The Medical Information Bureau is a nonprofit membership organization of life insurance companies. The Bureau provides an information exchange for its members. It maintains information of underwriting significance on policyholders and applicants as furnished to it by member companies. Such information is available only to member companies and only when such company has an authorization signed by you to request such information.

We use the MIB to check information of underwriting significance, but only as a guide to identify areas about which we might need additional information before reaching a final underwriting decision. Columbian Life does not rely, in whole or in part, on an MIB report in making a final underwriting decision.

We make a brief report to the MIB on those individuals about whom we have information about underwriting significance. We will not report what action we have taken on your application. The MIB, on request, supplies other member companies with information in its files if an application for life or health insurance, or a claim for benefits, is submitted to such company. MIB rules require that a member company have our authorization before requesting information about you.

If you question the accuracy of information in the MIB file, you may contact MIB, Inc. and seek a correction in accordance with the procedures set forth in the Federal Fair Credit Reporting Act. The address of the information office of MIB, Inc. is [50 Braintree Hill Park, Suite 400, Braintree, MA 02184-8734, Telephone Number (866) 692-6901 (TTY (866) 346-3642). MIB's website is www.mib.com].

FRAUD WARNING STATEMENTS

If the application already includes a fraud warning, the state specific warnings listed below prevail over the standard warning in the application.

The law in **ARKANSAS, LOUISIANA, RHODE ISLAND and WEST VIRGINIA** states: "Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison."

The law in COLORADO states: "It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado division of insurance within the department of regulatory agencies."

The law in **DISTRICT OF COLUMBIA** states: "WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant."

The law in **FLORIDA** states: "Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree."

The law in **KENTUCKY** states: "Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime."

The law in **MARYLAND** states: "ANY PERSON WHO KNOWINGLY AND WILLFULLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT OR WHO KNOWINGLY AND WILLFULLY PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE IS GUILTY OF A CRIME AND MAY BE SUBJECT TO FINES AND CONFINEMENT IN PRISON."

The law in **NEW JERSEY** states: "Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties."

The law in **NEW MEXICO** states: "ANY PERSON WHO KNOWINGLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT OR KNOWINGLY PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE IS GUILTY OF A CRIME AND MAY BE SUBJECT TO CIVIL FINES AND CRIMINAL PENALTIES."

The law in **OHIO** states: "Any person who, with intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud."

The law in **OKLAHOMA** states: "WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony."

The law in **PENNSYLVANIA** states: "Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concealing any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties."

The law in **TENNESSEE, VIRGINIA and WASHINGTON** states: "It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits."